PUBLIC HEALTH SERVICES DISTRICT
COCONINO COUNTY

Patient Registration Form

Patient Information				
Name: Last First				DOB (MM/DD/YY): / /
Age:	Male ☐	Female ☐	Transgender ☐	Phone #:
Street Address:				
City, State, Zip code:				
Mailing Address (if different from above):				
City, State, Zip code:				Alt. Phone #:
Email address:				

Ethnicity (circle all that apply):

African American	☐	Asian	☐
Native American	☐	White	☐
Native Hawaiian or Pacific Islander	☐	Hispanic	☐
	☐	Other	☐

Maiden name/Alias:	Mother's Maiden Name:

Guardian Information (if patient is under 18 yrs old):	
Last Name:	First Name:
Address (Street, City, State, Zip):	
Relationship to Patient	Phone #:

Emergency Contact (if different than Guardian):	
Last Name:	First Name:
Address (Street, City, State, Zip):	
Relationship to Patient	Phone #:

By signing below I certify that the information I have provided is true and correct to the best of my knowledge. I understand that I must report any change to my information so that any services or information given to me are provided accordingly. I understand that I will be asked to update my information annually or when changes have occurred. I hereby authorize CCPHSD to furnish information to my insurance carrier concerning my visit and I assign payments for medical services rendered by CCPHSD. I understand that I am financially responsible for all charges whether or not covered by my insurance plan.

Patient/Guardian Signature Date

Staff Notes: